MEDICAID FORM RELEASE MEMO

TO: FRM Distribution
FROM: Publications Control

FRM Number: NMO-1113 (03/09)
Issue Date: TBA
Effective Date: Upon Receipt

SUBJECT: **Health Insurance Premium Payment (HIPP) Program Brochure**

The following is for your information and action. Attached please find the revised form to be used. The actual form may vary in size, color, type of paper or printing method. Please update your FRM log and Forms Manual.

☐ NEW FORM
☐ REVISED FORM: Destroy old version after new stock is received.
☐ SUPPLY is being sent to all using offices.
☒ REVISED FORM: Use old version until supply is exhausted.
☐ Revised FORMS CONTROL INDEX
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PURPOSE:

The HIPP program is a cost-savings program that defers Medicaid costs to private health insurance. The purpose of this brochure is to provide information on the HIPP program such as requirements, benefits and contact information.

INSTRUCTIONS:

Distribute brochure

DISTRIBUTION:

Division of Welfare and Supportive Services
HMS
Reno District Office
DHCFP Website

Do you qualify?

- Does anyone in the household have health insurance offered through an employer?
- ~~Did anyone in your family lose a job within the past 30 days where you had health insurance?~~
- Is there someone in your family who is pregnant or seriously ill who has access to health insurance?

* Nevada Check Up recipients are not eligible.

Who to contact?

Enrollment in the HIPP program

HMS
PO Box 11707
Reno NV 89510-1707

Phone: (775) 335-1040
Toll Free: 1-800-856-8839
Fax: (775) 335-1050

Email: nevadahipp@hms.com

Questions about the program?

Division of Health Care Financing and Policy
Provider Support Unit
1000 East Williams Street
Ste 205
Carson City, NV 89701

Phone: (775) 687-8413
Fax: (775) 684-3775
Email: HIPP@dhcfp.nv.gov

State of Nevada

Division of Health Care Financing and Policy

Provider Support Unit

Health Insurance Premium Payment (HIPP) Program

NMO-1113 (~~08/08~~)

Health Insurance Premium Payment (HIPP) Program

The HIPP program is a cost-savings program, which identifies Medicaid recipients with private health insurance available through an employer. Medicaid pays the medical premiums, co-insurance and deductibles for eligible recipients when determined to be cost-effective.

Taxpayer dollars are saved by purchasing health insurance available to Medicaid recipients because high costs are deferred to the private insurance. The program assists recipients in paying employer premiums they otherwise may not be able to afford.

Requirements

- Eligible for full Nevada Medicaid
- Have access to private insurance known as Third Party Liability (TPL)
- Have a catastrophic illness or condition including pregnancy, and be determined cost effective
- Cannot be eligible for Medicare
- Changes to employer health premiums may result in disenrollment from the HIPP program if no longer a cost savings.
- If it is determined that paying the group health insurance is cost-effective, then recipients are expected to enroll in the HIPP program. Non-cooperation may result in being ineligible for Medicaid.

Benefits

- Other medical services may be included if covered through the employer health insurance.
- Non-Medicaid household members do not qualify for HIPP. If medical coverage cannot be separated by family member, and does not increase the premium amounts, then other household members may be eligible for insurance services.
- Participation in the HIPP program provides Medicaid recipients an opportunity to receive health insurance that may not have been affordable while saving taxpayers dollars.
- Once recipients are no longer utilizing the Medicaid program, individuals can take over their premium payments without waiting for the next open enrollment period.

Do you qualify?

- Does anyone in the household have health insurance offered through an employer?
- Is there someone in your family who is pregnant or seriously ill who has access to health insurance?

- Nevada Check Up recipients are not eligible.

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NMO-1113 (03/09)

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NMO-1113 (03/09)

MEDICAID FORM RELEASE MEMO

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FRM Number: NMO-5000 (03/09)
Issue Date: TBA
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SUBJECT: **Health Insurance Premium Payment (HIPP) Program Application**

The following is for your information and action. Attached please find the revised form to be used. The actual form may vary in size, color, type of paper or printing method. Please update your FRM log and Forms Manual.

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PURPOSE:

The purpose of this application is to determine other medical insurance available to Medicaid recipients to reduce Medicaid expenditures and defer costs to private health insurance.

INSTRUCTIONS:

Recipients complete the application and send via mail, fax or email to HMS for determination of program eligibility

DISTRIBUTION:

Division of Welfare and Supportive Services
HMS
Reno District Office
DHCFP Website

Health Insurance Premium Payment (HIPP) Program Application

The purpose of this form is to determine other medical insurance available to help pay your medical costs. Please answer all of the questions to the best of your ability and sign the application. Attached is a HIPAA release form that also needs to be signed in order to verify the information contained on this form. If you have any questions or need help completing this form, please call **(775) 335-1040** or toll free at **1-800-856-8839.**

Date	Recipient Name	Medicaid ID

Answer these questions about the person with *access* to health insurance

Policy Holder Name	Social Security No.	Policy No.	Group No.

Employer Name	Address	City	Zip Code

Monthly Premium Amount (Amount **you** pay for insurance. Enter zero if paid by others.) $ _____

How often is your insurance paid: ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Quarterly ☐ Other

How is monthly premium paid to insurance: ☐ Payroll deduction ☐ Automatic WD ☐ Check ☐ Other

What are the yearly deductibles for the health insurance: Single $_____ Family $ _____

If all Medicaid eligible members of your household are not currently enrolled in your employer health insurance, can you or your family members still enroll? If yes, what is the earliest date: _____

Insurance Company Name	Address	City	Zip Code

What type of insurance is available:

☐ Major Medical (including hospital, outpatient, physician, etc) ☐ Dental ☐ Vision

☐ Medicare ☐ Prescription Drugs ☐ Health Maintenance Organization (HMO)

~~If you have lost your job for any reason and are eligible for COBRA, what is the last day to enroll:~~ _____

For Medicaid recipients, please list any catastrophic health condition: _____

_____

Please list other household members that are currently, or would be, covered by your insurance

Name (Last, First)	Birth Date	Relationship to insured	Social Security No.	If this person is eligible, what is their Medicaid ID No.

_____ _____ _____

Signature of Applicant **Date** **Telephone Number**

This application can be faxed to **(775) 335-1050** or mailed to HMS at PO Box 11707, Reno, NV 89510-1707

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